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Quality Measurement and Data Collection Special Issues -- Part 2 of 2

Peggy O'Brien: Good afternoon. Welcome to the second webinar in the Behavioral Health Clinic Data Collection and Quality Reporting Webinar Series, presented by the Substance Abuse and Mental Health Services Administration. Today's topic is Quality Measurement and Data Collection Special Issues -- Part 2 of 2. I'm Peggy O'Brien, a Senior Research Leader at Truven Health Analytics, presenting on behalf of SAMHSA. Today we also have representatives of ASPI and CMS present. And we have two special guests, Mary Cieslicki and Virginia Raney from CMS who will talk about Quality Bonus Measures and Payments.

There is a chat function where you can ask questions, and we encourage you to do so. We'll pause at several points to respond to questions people have asked about things we've covered that may be confusing or about related matters. Most webinars have at least one poll question which listeners will have time to answer and which we can discuss.

A PDF of the slides for each webinar is posted as a resource on the webinar site, and the webinars themselves will be available on demand for a year after the event on the webinar site where you are listening to this presentation. All you need to do to access the on-demand webinar on the webinar site is to register. So if you know someone who has not done so, who would benefit from accessing this webinar, or previous webinars, please encourage them to register so they can access it.

The webinar also will be posted on the SAMHSA website, probably within a week or two after it is presented, and it is also available on the SAMHSA YouTube site. At this point, webinars one through five have been posted on the SAMHSA YouTube site.

This is the webinar schedule with the intended audience identified in red. All are on Tuesday from 2:00 to 3:30 Eastern Time. The next webinar is the last in this series of eight, and it is week after next. We will be skipping next week. The eighth webinar will cover the BHC measures that are not required as part of the demonstration program. I also hope to address some lingering, unanswered questions then, as well.

Today we will be covering a range of topics including Quality Bonus Measures and Payments. Some lessons learned from the state visits that we undertook in the spring. I also will go through a number of outstanding questions from earlier webinars. I will do this again on the webinar in two weeks. With that said, I will turn the floor over to Mary Cieslicki and Virginia Raney of CMS.

Mary Cieslicki: Hi. This is Mary Cieslicki. Welcome to the discussion of the Quality Bonus Measures used for the Section 223 demonstrations. Here are the topics we're going to be covering today, the measures used for the quality bonus payments, setting measurement targets, determining baseline data, state considerations for payment, timing of a QBP, QBPs and dually eligible beneficiaries, state access to dually eligible beneficiary data and QBP measure resources.

As a reminder, I think the slides should look very familiar to those of you who have been reviewing the PPS guidance. As a reminder, these are the required Quality Bonus Measures for the Section 223 demonstration. For the state to make a Quality Bonus Payment, the CCBHC or certified clinic, must demonstrate that it has achieved on all of these. And these are the six measures that it must achieve on before a QBP payment can be made.

And these -- and you'll find these by the way in the PPS Guidance -- and these are the additional, optional QBP measures. They all are required to be reported, but the state has the option of making payment on these or not. Payment on these depends on first, meeting performance goals for the required set of six measures that were shown on the previous slide. And the state can also suggest additional measures for quality bonus payments, but again the performance goals on the first six, must be met. And CMS must approve any quality -- any additional measures proposed by the state.

Virginia Raney: This is Virginia Raney. The following should be kept in mind with respect to the quality bonus payments. In the demonstration application, the state is required to document its QBP methodology, including how it will set measurement targets for payment. Part of determining how to incentivize using QBPs, it's important that you consider what the state's health needs are, such as what we've learned in the state's needs assessments. Each state will probably reflect different health needs.

The target should be equitable for all of the clinics, for example, rural and urban sites, governmental, and private. The target should promote quality improvement, and CMS will review and approve the Quality Bonus Payment plans.

Setting this target, QBPs may be based on the clinic's attaining a certain level of performance on quality measures, improving on past performance on the measures, or a combination of both. So in looking at improvement comparing before and after -- before and after is based on that clinic's data. When looking at improvement, payment for improvement should be for meaningful improvement.

Thresholds can be set using absolute levels of attainment, for example, a state could require that CCBHCs much reach a given level on the Medicaid for a substance use disorder to meet initiation and engagement level measure, in order to be eligible for a bonus payment. Thresholds can also be set on the basis of relative performance based on rank, compared to the appropriate peer group. For example, a state could require that CCBHCs reach at least the 75th percentile of performance among all CCBHCs in the states reporting on a measure. In this case, CCBHCs will be rewarded if they performed better than the 75% of their peers within the measurement period.

A possible drawback to consider of competitive incentive such as this however, might be, discourage cooperation and information sharing between CCBHCs which could help improve the performance.

Determining baseline data. States will need a baseline and a target for each year. The application should provide a plan for establishing those. Baselines for demonstration year

one may be based on the state's HEDIS data. States that are currently reporting HEDIS data will already have the information on the following four required quality bonus performance measures. The follow-up after hospitalization for adults and children, the suicide risk assessment measure, and the follow-up -- the substance abuse initiation and engagement measure.

Additionally, states may be able to access HEDIS data on several of the optional QBP measures which are also NCQA or HEDIS measures. Additional sources of information may be from the state's Medicaid core set measure reporting, existing data that's collected by the BHC. States may also want to consider data collected during the planning grant year, or during the first three or six months of demonstration year one, as their baseline. And as a last resort, a state might consider using rates from other sources outside of the state. The baseline for demonstration year two, will be the demonstration year one results.

Mary Cieslicki: So we'd like to pause at this juncture. And ask if there are any questions or comments.

Peggy O'Brien: There will be another opportunity for questions in a few slides.

Mary Cieslicki: Okay. So state considerations for payment. In thinking about how to pay QBPs, the states should remember that the provider must achieve on all six required measures to be paid any QBP. The state should consider the need for flexibility in target modifications, although the application must provide the preliminary approached target setting. Flexibility is allowed later with the target set -- initially set is unreasonable. And remember that no prospective QBP is allowed, meaning payment cannot be made before the measure has actually been achieved by the provider.

Another consideration is when making a lump sum QBP, the state must allocate the cost of the payment using the FMAPs specified in section 223 d(5) of PAMA. The state also will want to consider timing of payment, which we'll talk about in the next slide, and the availability of data. And we've been referencing the application, and specifically the QBP is addressed in section 2.1.b in the demonstration application.

So timing of the QBP payment. When to pay is determined by the state. The state should consider when the quality measures have to be submitted. In deciding when to pay the state should consider when the quality measures have to be submitted. CCBHCs have 9 months after the end of -- after the demonstration year ends, to submit data to the states. And states have 12 months after the end of the demonstration year to submit quality data to SAMHSA.

This timeframe allows states an opportunity to review data from clinics before submitting it to SAMHSA. You also may want to consider when data are available to complete the measures including both provider data submission and measurement period requirements for data in the specs. Two possible approaches to payment include, one, annually after submission of the quality measures to SAMHSA or two, more frequently during the year. This has the advantage of requiring earlier determination of progress and opportunity for

improvement as well as greater incentive to aim for payment on the next short-term payment. I think what we're saying in plain English, in plain language is that, if you make payment during the year, it offers a more -- a quicker feedback loop, and may serve, may spur the providers on in terms of improving payment -- improving quality.

Okay QBPs and dually eligible beneficiaries. The states and clinic should be reporting quality data for all dually eligible beneficiaries to the extent possible. For QBP data, the state may elect either to include data on all dually eligible beneficiaries or only the set specified low-income Medicare beneficiaries, the SLMBs, or qualified Medicare beneficiaries, the QMBs. Those are the only two types of dually eligible beneficiaries whose services are paid at the PPS rate. As you may recall, we addressed that in Qs & As on medicaid.gov.

More information about the requirement to pay the CCBHC PPS rate for these two populations, the SLMBs and QMBs, is found at question number 2 in set 3 of the Qs & As posted on medicaid.gov.

State access to data on dually eligible beneficiaries. States will use the normal means to access this data as they do not -- as they do for cost sharing. Some factors that will play into access may include whether it is Medicare managed care data, whether they're a part of the coordination of benefits financial alignment initiative, whether it is part D data. If it is part D data, we have provided a link to the CMS guide for requests -- to make requests for part D data.

Again, state should report data on a dually eligible, to the dually eligible beneficiaries to the extent it is available, and if it's not available, then this should be indicated in the notes on the recording templates.

Quality bonus measure resources. We have a number of resources. First, there is the RSA, SAMHSA's RSA and of course, there's the PPS Guidance. And in our PPS technical assistance webinar on quality bonus payments, you can -- there, you can find more information about the QBP, and of course we have questions and answers, and that along with all of the webinars, is posted in the dedicated SharePoint site for this demonstration. And there on SAMHSA's website, of course you'll find the quality measures, technical specifications and data reporting templates which were approved by OMB.

So at this point, we'd like to see if there any questions or comments.

Operator: There's a question from Margaret Morris. If HEDIS measures are used, how does the plan deal with demonstration years that begin in July, whereas HEDIS data is a calendar year?

Virginia Raney: The technical specification attempted to provide information on various starting dates for the demonstration. When we're talking about using the HEDIS data to provide information on a baseline or a threshold for a quality bonus measure, you could use full year's data, or if you have the information for the previous quarter -- which some states have collected it that way -- that might be another option. We were trying to

brainstorm, various ways that we thought states might already have some information that they could use for their baseline so that they're not having to start from scratch.

Operator: There are no additional questions at this time. I'm sorry, there's one question. What is the quality measure website?

Virginia Raney: It's on medicaid.gov

Mary Cieslicki: Actually, the OMB approved document with the technical specifications and the reporting templates, is on the 223 landing page of SAMHSA, and I want to say, we've included the link to it.

Virginia Raney: Yeah. And if you have any questions about this, you can also submit measures to the 223 mailbox, and they will forward any appropriate questions to the CMS Division of Quality.

Mary Cieslicki: Right. So we also wanted to provide a clarification, which is, we've emphasized of course, the clinics have to achieve on the six measures before any quality bonus payment can be made. And I think a natural question would be, can a state, not make payments if a -- can a state set a threshold and say -- we're not going to make payment unless a clinic achieves on the six measures, plus let's say, two optional measures.

And our response is that, you have flexibility. You can decide that you're not going to make payment until they have achieved on six, plus additional measures. But of course, the overall goal is to improve quality, so in coming up with your strategy as to which additional measures you're going to use, and when payment is triggered. Obviously, that would need to go -- that would need to go hand in hand with what you're goals are for improving quality.

Operator: And there's a follow-up comment from Margaret Morris, HEDIS data are provided annually by the MCOs.

Mary Cieslicki: Could she be a little more specific about the question about that?

Operator: There's another question from Bob Blau. In the PPSTA project timeline shared by CMS with the states, it was indicated that specifications for any state-defined quality measure to support the QBPs, should be submitted to CMS by August 2016. Has guidance been issued on this, and if so, where?

Mary Cieslicki: So when a state is proposing a quality measure, we're evaluating each proposal on its own merits, so beyond -- there is no additional guidance that has been issued beyond the OMB approved, tech specs and reporting templates. So if your state is interested in proposing a measure, you would submit that, and we would evaluate it and work individually with the state.

Operator: And there's a follow-up comment from Margaret Morris. In reference to using the data to evaluate performance during a demonstration year that does not align with the calendar year, states will not be able to determine performance for a portion of the year.

Mary Cieslicki: Because the HEDIS schedule is different than the calendar year. We understand that a lot of states will be starting their CCBHCs at various timelines along the way. So we've asked them to collect and report on the data that the CCBHCs -- while the measures are HEDIS measures, that does not necessarily mean that they are required to be submitted into HEDIS.

Well, we understand that the HEDIS timeline starts in June, for that kind of submission, I don't know that CCBHC measures necessarily have to follow that timeline specifically as that's not how the data is collected for that issue. But if you like to submit that question in writing, we will be happy to provide more detailed guidance formally.

Operator: There are no additional questions at this time.

Virginia Raney: Yeah. I think that the two big takeaways that we have for the data with the quality both those measures, as well, as the other measures is, you know, we know that some of these measures are difficult to collect, and that getting all of the information for all of the members of the CCBHCs might be a little bit of challenge. So we're asking states to do the best they can to collect and provide all of the information that they can, based on the technical specifications that are on the 223 website. And if there are any deviations from the technical specifications as Peggy has told us during previous webinars, please note that on the reporting template so that we're aware of any deviations.

The same would apply to quality bonus measures that we are proposing.

Mary Cieslicki: [Kristen], are there any other comments or questions at this point?

Operator: No. There are no additional questions at this time.

Peggy O'Brien: Okay. So thank you Mary and Gigi. I'm sure everybody was happy to hear somebody other than me speaking for a change. Now, I'm going to switch gears. And share with you some information and lessons learned during the three state visits that we undertook in the spring.

So a team from Truven visited three states in the spring of 2016 to determine how best to structure these webinars and what to include. We met with state officials, providers, and managed care entities, and some behavioral health council representatives. SAMHSA was not informed of which states we visited in order to prevent any potential effect on the selection of states for the demonstration. The lessons learned can be useful whether or not the state is part of the demonstration. For example, if other initiatives involving quality measures are implemented. We gained a lot of very valuable information, and have really been unable to cover it all in this series.

What I will impart today is a tiny slice of some of the general lessons learned, and to the extent I have been able to, I've incorporated more specific lessons learned into the webinars as we've gone.

So SAMHSA requested that states volunteer to contact us, which is Truven, and the three states that we visited were selected based on the factors that you see on the slide. We looked at geographic representation by region, so that we got diverse representation from across the country. We looked at predominantly urban versus rural versus mixed states, to get some diversity there. We looked at whether a state expected many or few BHCs to be certified, so that we got a mix of those with a very limited number, and those with many more. We looked at different levels of integration of mental health and substance use disorder treatment, different levels of managed care penetration across states, and at the special populations of interest that had been identified by the states.

From the visits, we developed a road map for implementation. As you can see, it's windy, with a lot of bind curves. Many of you are already well down this road. And I know, states will all be at different stages. So some of the things I say here, will seem obvious to many of you. I'm hoping that each of you though, can pick up something from this. So for the quality measures, step one, might be review of the measures. And in doing so, think about which measures are new for you, and which you're already collecting.

You will want to build on and learn from your current quality measure activity in the state for other programs. For instance, FQHCs, meaningful use and health homes. Which reminds me, we are in the process of doing a comparison of all the BHC measures that are also PQRS measures. And we will be providing information on the extent to which there is divergence as soon as humanly possible.

We know that this will help those of you who are already reporting PQRS as you move forward. And because we are only in the process of doing this comparison now, I can report on three of the measures that are simultaneously BHC and PQRS measures. The TSC measure, which is the tobacco screening measure, the alcohol screening measure and the adult BMI measure for purposes of the specifications and how they are calculated, those are the same. There obviously are differences in payer mix, and payer stratification, but you will be seeing something in writing that provides a summary of what we find when we finish that comparison.

So moving on, you will want to map your data systems. Look at the data systems that need to talk to each other, to generate the quality measures. And I'm speaking here about, within the state systems, within the BHC systems, and systems that may need to function between the state and the BHCs.

Ask how centralized are the data collection and reporting systems in your state. What does that mean or the date reporting? And what are you going to have to do, to address the ability to work across systems?

You'll want to ascertain EHR capabilities. For example, are the data fully accessible for the CCBHCs? The BHCs should review their contracts if they have data that's hosted

elsewhere to see if there's any issue with accessing data as needed. Are the EHR systems flexible to adaptation? And are they compatible with state systems? Will there be a way for the BHC data to get to the state? Can the EHR vendor easily and quickly program for the new measures? And I know that's asking a lot. And can the BHC easily program if necessary?

And think about whether new measures might require hand entry or batch entry, will you need to develop a mix system with some hand entry and some automated? For instance, thinking about the DCO data. At the same time as the previous step when you're thinking about the data systems across the state and within the state, you also will want to pull together an interdisciplinary working group at the state and BHC level to review the measures and map the systems. And these can be separate. I mean, they don't have to be state and BHC, they could be state on one hand, and BHC on the other hand. Potential participants for the state could include the state Medicaid and Behavioral Health Agencies, state IT and Data Analytics personnel, Quality Specialists, Medicaid Managed Care representatives, External Quality Review Organization representatives, and then obviously, the CCBHC Program representatives.

And for the BHC, develop a quality leadership team that includes staff, such as your CEO, Clinic Administrators and Operations personnel, quality representatives, IT staff and providers. And I know, it's easier said than done, but try to assure consistency in teams over time. You also will want to develop and implement IT quality and testing protocols.

For hand entry, identify fields that can include built-in quality checks, such as data validation, lead time to test and refine the systems, and integrate provider feedback into systems development to see what will actually work in terms of providers, coding, and what is needed by providers to make this work. Establish a dataflow work group that adopts the changes and cross checks reports with information in the software, and integrate a process that allows interim reporting and feedback, prior to year-end. This gets to both data quality control, and continuous quality improvement.

You will want to institute data collection training, and training protocols. These should take account of provider buy-in at the BHC, streamlining new data collection into existing systems whenever possible, developing training protocols and mechanisms for feedback loops to IT staff because there will be glitches, provide regular feedback to providers on the results of data collection and quality measure processes, and to the extent it makes sense, use these webinar as a basis for developing your training.

And don't forget CQI, which I discussed last week. Here are some other things you might want to think about as you plan and implement.

For states, how do you manage attribution of a client to a BHC in the state data? For states again, consider issues of timeliness and access to data on dually eligible enrollees. Think about the degree of managed care penetration in your state, what that means in relation to remaining fee-for-service beneficiaries and the data for both groups, the

movement of individuals among MCOs and access to data for the eligible population in MCOs.

So, what are the effects of having a PPS or having managed care? How do you accurately report encounters where payment is bundled? Important. For both BHCs and states, how will you obtain data from DCOs? Will BHCs have them, enter them into their system, provide data some other way, or is the information available to the state directly from the DCOs? For BHCs and states, do data actually reflect what's happening on the ground? For instance, coding for substance abuse diagnoses and coding of certain HCPCS G codes. What burden is going to be imposed on the clinic? Is there duplication of data entry for providers across multiple systems? Is there a way to streamline things?

Building an interdisciplinary team, I have mentioned this a couple of times. This can help you understand problems and systems development through multiple lenses and understand the different perspectives and roles that people have so that you can take account of those perspectives. And then consider how 42 CFR Part 2 might affect your decisions. Are the substance use and mental health data in your state unified or separate? Can the state calculate measures capturing the entire relevant population if the data are separate? Bringing the different agencies together that have a role to play in this will be important.

If you approach the task, try not to shortchange the planning process, build in necessary meetings and processes to develop this new system. Part of it may be -- try to be patient with the iterative process of identifying and fixing glitches that will occur. Can you create or make use of efficiencies? Do you want to create systems for just CCBHCs or for a larger number of BHCs in your state? Do you want to collect the data on all clients and carve out CCBHC clients for reporting?

Try to leverage the current data systems at the state and clinic level as much as possible in development of the BHC quality measure system, and consider the flexibility of your data systems to tweak the coding needed to capture the measures.

BHCs that are working on this might want a timeline to complete necessary processes. You probably already have this, but just in case, I'll point it out that you might include developing the data systems, programming the specs, testing and validating the systems, training providers to make sure that they know the coding and what is required, and ensuring consistency in provider entry. Though that will entail, among other things, auditing and follow up and checking. And as part of collaboration at the clinic level, try to use the interdisciplinary planning teams, feedback loops from IT to providers, and back again, and having consistency in membership on the teams over time.

And last but not least, try to keep this in perspective. There is never a perfect measure, and although not perfect, measures can be used to improve care. As a few examples, they can shine a spotlight on systems improvements; for example, integration of care for physical and behavioral health issues. They can focus on improved coordination of care after ED visits or hospitalizations, and they can support consistent medication management, and these are just a few examples.

So now, we have a survey and I don't want to pressure anyone, and this is totally anonymous, no one knows who is going to give the answers to these polls, but if you could provide an honest answer whether you are a state or a BHC, how ready do you believe you are to implement the quality measure process at this point? Please pick one; Not at all, Somewhat, Okay given the time that we have left, Good, Great or I'd rather not say.

I'll wait a minute and let you decide what answer you think is best. Okay, we're going to move on and see what results we got. Okay, 13% Not at all, 40% Somewhat, 30% Okay given the time we have left, 12.5% Good, less than 1% Great, and 3% I'd rather not say. Okay. I really didn't know what to expect with this one. Interesting.

So I'm going to move on to some outstanding questions, starting with general questions and moving on to specific measures. But before I do that, I want to stop and see if we have any questions, Kristen?

Operator: There are no questions at this time.

Peggy O'Brien: Okay. If somebody wanted to know how to access the slides to the webinars that were previously held that they could not attend, the slides are available for download as a PDF on the webinar site and the webinar itself can be viewed on demand on that site. You do, however, have to register for each webinar separately. The webinars also will be on the SAMHSA website as soon as they're posted at the address that's on the slide.

This gets back to something that Mary mentioned in her discussion earlier. This is the question that we've gotten, would Medicaid, QMB and QMB Plus beneficiaries be defined as Medicaid-Medicare dually eligible or as Medicare beneficiaries for purposes of stratification and quality bonus payment? QMB is equals -- Medicaid pays for their Medicare premiums but does not cover service that's not covered by Medicare. Both QMBs and QMB Plus beneficiaries are treated as dually eligible for purposes of stratification.

Somebody asked, providers have up to one year to file a Medicaid claim, what does this mean for CCBHC reporting deadlines? We know that the states have up to a year after the demonstration year ends to submit the quality measures. What do we do if we get claims after that point?

The response to that is -- as part of the Medicaid rules, states actually have up to two years to make claim adjustments under the 2-year timely filing rule. Although, the states might have additional time to seek reimbursement after the year in which the data must be reported for the demonstration, the evaluation time constraints mean that for the measures, the data available by the 1-year deadline for submission are what will be used for the evaluation.

Someone asked, what validation of quality measure rates submitted will occur?

BHCs and the states should be engaged in data and measure result validation, although there is no specific requirement for such in the criteria. Neither SAMHSA nor CMS will be validating the results reported by the CCBHCs or states as part of demonstration program.

This question asks, measures assume CCBHCs will monitor customer use of EDs and follow up as needed. Does SAMHSA have examples of formal agreements that CCBHCs enter into with EDs about shared data for care coordination purposes? For example, client ID and diagnosis from ED visits.

This is a very long answer that's on two slides, I apologize and I'm going to read it to you. SAMHSA does not have examples of such agreements. Much of the information provided earlier about agreements with DCOs may be applicable. So, thinking back to a separate webinar that was conducted by SAMHSA related to formal agreements, you might find some information there that is useful for this purpose too. Also, although it's a different realm, Accountable Care Organizations or ACOs have been working on this for several years now and it is something that requires persistence and flexibility to find a process that works.

One thing that has helped is to have agreements with hospitals to assure that providers know that there has been an admission. It's very important and criteria do call for care coordination agreements. BHCs will need to enter in to such agreements with facilities most likely to be their care coordination partners. Those agreements might call for some or all of designation of individuals on both sides, who will be responsible for alerting and receiving information related to ED use, provision for inquiry of individuals seen in EDs for psychiatric or substance use purposes if they're BHC consumers, provision for releases of information that allow information sharing regarding the ED visit, and provision for care coordination meetings to advance the processes and systems of care coordination. Other provisions might also be included.

Many hospitals will already be in a position of needing to better coordinate aftercare and overtures and agreements such as this, may actually be welcomed by hospitals as a way to facilitate that. The FMAP for enhancing health information exchanges for non-eligible providers in order to help eligible providers meaningfully use EHR may play into this. And for those of you who may not be familiar with this, there was a state Medicaid director's letter, and I believe February of 2016, that discusses this. And I believe that SAMHSA is planning a potential webinar about this subject.

For measures, such as the one for follow up after a person is seen at the emergency department for alcohol or other drug dependence treatment, what if the person is a Medicaid enrollee that is seen in a residential treatment program or some other substance use disorder program that is not paid for by Medicaid in the state? So the data will not be available as Medicaid claims data.

The response to that is, if the Medicaid enrollee is seen somewhere that is not captured in the claims data, the BHC or the state should indicate that the data are not available and

why. And you can use the data reporting templates sections E and F. This will affect your rate and you will want to acknowledge that in the data reporting template.

For the measure relating to timing to initial evaluation, what is the definition of first contact?

For this measure, it's important to remember we're looking back six months before the time they're seen to determine if they are a new consumer. Assuming that this is someone not seen at the BHC in the past six months or ever perhaps, first contact usually will be a call looking for an appointment or a walk-in looking for an appointment. The first contact also could be a crisis service provided by the BHC.

The certification criteria at 2.b.1 require that at first contact, there will be a preliminary screening and risk assessment to ascertain acuity of needs. Depending on the results, the first service and the initial evaluation is required within 10 business days if needs are routine. If needs are urgent, the initial evaluation and service must be within one business day and if the needs constitute an emergency, the criteria say appropriate action must be taken at once. An initial evaluation as defined in criteria 43 should be incorporated into the emergency evaluation process conducted by the CCBHC.

Also related to initial evaluations, if someone receives an inpatient prescreen and there's a call later for services, would this be considered a new consumer?

The inpatient prescreen would qualify a person as a CCBHC consumer if the CCBHC included the preliminary screening and risk assessment and gathered other basic information about the person.

They would be a new consumer if they have not been provided services by the CCBHC in the past six months. An initial evaluation should then be conducted within ten days, sooner if they meet certain characteristics that are indicated in the certification criteria at 2.b.1.

And we have -- as you can see, here's another question about initial evaluation. There have been a lot of questions about initial evaluation and what is first contact and what triggers the need for the evaluation. And we're planning on trying to assemble all of these questions and answers about first contact and initial evaluation into one place so that they are easy to find. But I'm going to continue answering them on the webinar as well.

So there are actually two questions on this slide. The first is, if the program has open access where clients can come in whenever they want during certain hours, but they happen to call first to determine what the open access hours are, is that call considered first contact?

The answer to that is no. A call to determine when open access hours are held is not first contact unless that call is accompanied by the preliminary screening and risk assessment and collection of basic data about the person including insurance information. In general, however, if a person calls just to find out what hours you are open, that is not initial contact. That is an attempt to find out when they can come in and have an initial contact.

The second question is, if a consumer calls seeking an evaluation and we provide them with our own open access and they never show, is that counted in the denominator?

Yes. Assuming you performed the required preliminary screening and risk assessment to determine level of acuity when they called.

Is a PCP referral considered the first point of contact?

No. It has to be a contact by the person who's seeking services or by their family or guardian if they are a child or have an appointed guardian. The first point of contact is the person seeking services so their acuity of needs can be determined using the preliminary screening and risk assessment that is supposed to occur at first contact.

Can your first contact be entering into level 3 detox if it's part of the CCBHC and then they enter into follow-up outpatient care within 10 days?

Level 3 detox that is either inpatient or residential is, by definition, not a CCBHC demonstration service. If there is a pre-screen at the detox that satisfies the requirements of making someone a CCBHC consumer, preliminary screening and risk assessment by the CCBHC, then the results of that regarding acuity of need would govern when the initial evaluation must be performed.

Okay. Moving on to a different measure, screening for clinical depression and follow-up. For the measure of screening for clinical depression and follow-up planning, I see PHQ-9 listed. For kids, can the PHQ-A be used?

The PHQ-A is a standardized instrument designed for adolescence and was developed by those who developed the PHQ-9. It's always preferable to use an age-appropriate instrument and the measure does not limit instruments that can satisfy the numerator to those that are listed in the definition of standardized instrument. Rather, the measure only requires that screening tool be standardized and some examples are provided. And among those examples are the PHQ-9. So that list of examples of standardized screening instruments is not an exclusive list. There will be other tools or instruments such as the PQA -- PHQ-A which also could be used.

On the same measure, would it be viewed positively if all who scored positive on the scale, the PHQ-9, were excluded due to active diagnosis of depression?

Okay. This is another one of those ones that I'm going to give you a long answer to and I'm going to kind of reiterate the lay of the land for the measure.

During the webinars, we always try to explain how the rate achieved on the measure is related to quality. Here, for this measure, a higher rate of screening and, where needed, follow-up planning, is associated with higher quality because the goal is to consistently screen recipients of services at the BHCs for depression and provide follow-up if the screen indicates it's needed. This is designed to improve identification of those in need and the provision of necessary services.

The question seems to assume that the BHC can screen individuals and then if they are found to have depression, exclude them from the denominator. And if you're excluded from the denominator, you're excluded from the measure.

That is not how the active diagnosis of depression comes into play and using it that way would defeat the purpose of the measure. Rather, because the purpose of the measure is to encourage new identification of depression with resulting treatment, anyone who is already diagnosed with depression or bipolar disorder is excluded from the measure completely so you're only capturing those without an active diagnosis -- yeah, without an active diagnosis. From those you conduct screening and if depression is found, you provide follow-up planning. So those counted in the numerator are the subset of those who are not excluded because of existing diagnoses or other exclusion criteria and who are either screened and found not to have depression or screened and found to have depression and then provided follow-up planning.

And I got carried away and made a picture to depict this. And I actually found this a useful way to think about it. You begin with the eligible population, the blue rectangle over on the left side of the screen. And that eligible population will be defined for this specific measure, perhaps age, seen at the CCBHC, as well as other things.

You subtract those in this instance with an active diagnosis of depression or bipolar disorder or certain other exclusions such as the person refused the screening, it was an emergency situation, there were functional or motivational concerns. And that when you've subtracted those exclusions equals the denominator, then you determine the numerator. So if they were screened and there was no depression, they go into the numerator and get counted. If they were screened and there was depression and a follow-up plan was documented, they also go into the numerator. If they are not screened or they were screened, depression was found but no plan and was made for a follow-up, they are not included in the numerator.

Once again, related to the measure of screening for clinical and follow-up. How do you define an encounter? Is it any provider, therapist, MD, NP, PA, et cetera.

The answer to that is that codes that indicate whether there is an eligible encounter that will get the person into the denominator are provided in the source measure. They include codes for services such as psychiatrists, a masters level clinician, a psychologist, primary care physician or others might utilize. You should review the source measure link in Section A of the specification to ascertain precise codes and then who, within the licensure and other requirements that may apply, can provide the eligible encounter.

Also related to that measure, if the consumer is receiving therapy, how can they use the codes in conjunction with the therapy codes for screening and planning? And the codes that are being referred to here are the G codes that indicate screening occurred or didn't, follow-up planning occurred or didn't or if there was an exclusion.

So the response to this is for the eligible encounter that gets them into the denominator, which is the encounter in which the numerator screening and planning are to occur. You

should look at the codes that the specification identifies for the eligible population. They're located in the source measure linked in Section A of the specification.

For the G codes that were used to indicate numerator compliance or non-compliance, it appears that not all states have them turned on. Now, this may be an overly simplistic answer and I would love to hear feedback on it. But some options would be for, one, the state to turn them on for the BHCs or for clinics to find ways to modify their EHR to accommodate the codes for internal purposes, training clinicians to use them and then using them to calculate the measure.

Also, related to that measure related to clinical depression and follow-up planning. If we incorporate codes, can you use sampling from the baseline year since the codes are not currently being used? And again, these codes are the G codes.

First, you will use billing or encounter data from the measurement year -- that is the demonstration year for the CCBHCs -- to develop the eligible population or denominator. Second, for the numerator, whether you sample or you use the entire eligible population, you also use data from the measurement year. So if prior to DY1, you did not use the G codes but you began using them in DY1, you will have what you need to calculate this measure. If you do not put the codes in place, you will, however, have to do a more detailed record review.

Moving on to the measure of adult BMI. This was from Michigan. The State of Michigan does not have a billable code for medical assistance to take BMI vitals on the behavioral health side of the CCBHC. Would medical assistance be allowed to take vital signs for BMIs?

There is nothing in this measure that specifies what kind of provider it has to be beyond the required use of encountered codes to establish the eligible population visits for the denominator. So this raises two questions, is there anything in state-licensing laws that preclude a medical assistant from taking vital signs for BMIs? Two, within the CCBHC demonstration program, can a CCBHC treat it as an encounter for purposes of the PPS and Medicaid reimbursement? Because the state plan does not limit the provision of CCBHC services is part of the demonstration program, that alone should not be an impediment.

We got a lot of comments related to the G codes that are used in the measure of screening for clinical depression and follow-up and for similar measures. The G codes are used to indicate things such as exclusions or that both screening and follow-up were done, were relevant, are with BMI if the BMI was in a certain range and whether or not appropriate actions were taken. So they are not billing codes per se, but quality codes. The comments fell into three categories.

The first two comments you see here indicate that some states do not have these codes in place or states may not allow behavioral health providers to use them. These concerns by BHC should be raised with the state CCBHC program if your state is applying to the CCBHC demonstration program.

The second two comments indicate concerns about providers not using the codes, resulting data inaccuracy and the need to audit compliance. Yes, there is work that will have to be done to educate providers related to coding as well as the processes that are called for by the codes and measures. And, yes, auditing is a good idea as it is repeated and consistent education with new and existing providers that will help assure that the codes are actually used properly if they are turned on.

And the final comment provides a helpful hint. I believe I suggested that EHRs might be programmed to add these codes. It is possible that some systems will allow it and others may not. This commenter suggested SQL or a structured query language software to pull data and assign appropriate HCPCS codes.

So it is true. The consistent use of these codes will indeed be one of the big challenges that BHCs will face in calculating the BHC quality measures.

As I do every week, I include herein and on the next two slides charts showing the measures by abbreviation whether they're state or BHC lead, whether they're required as part of the demonstration program and in which webinar they are discussed. This slide contains those that are state lead and required as part of the CCBHC demonstration. These slides are included for you to refer back to so you can easily find the webinar that addresses a particular measure of interest.

And these are the ones that are BHC lead but also required as part of the CCBHC demonstration. And these are the ones that are not required as part of the BHC -- CCBHC demonstration all of which will be addressed in the Webinar 8 in two weeks.

So please submit any additional questions that you have to the CCBHC_data_TA mailbox. You see the address up on the slide about anything that we covered today, about material that's scheduled for the next webinar, other questions that you may have and we will attempt to respond to them in the next webinar or by some other means. And also please don't forget to submit CMS-related questions to CMS. And before I forget, Kristen, do we have any questions or comments in the Q&A box?

Operator: Yes. We have a question from Melanie Thomas. Where is the list of standardized tools that are referred to?

Peggy O'Brien: Okay. I believe that that refers to the screening for clinical -- no, that refers to the -- yeah, that refers to the screening for clinical depression and follow-up CDF-BH. And that is in the specification, in the definitions.

So if you go to the measure specification for the screening for clinical depression measure, it defines standardized instrument, I believe, is how it's phrased. And in there, it says the standardized instrument is one that has been validated, and so forth and so on, and then it provides a list of standardized instruments for screening for depression. And one of those is the PHQ-9 which the question was asked about, whether you could also use the PHQ-A for adolescents. And the way that definition is written, those standardized instruments are not exclusive. There are other instruments that exists such as the PHQ-A

and you can use those. All the measure requires is that that the instrument be standardized.

Operator: There's a question from Laura Larkin. Do all the CCBHCs within the state have to use the same standardized screening tool?

Peggy O'Brien: No, they do not. And that, I think, if I think about every measure, unless it specifies a single a measure that only one measure can be used if there are options like the screening for alcohol, with the AUDIT, the AUDIT-C and a single-question screen. You do have to stick to those three. You can't go beyond that and satisfy the measure. But the CCBHCs within the state are free to use whichever of those they feel is appropriate. And certainly for the depression screening, you're free to use any standardized instrument that is appropriate.

Operator: There's a question from Kara Froberg. Is it true that G codes can only be used for Medicare individuals and that they can only be used in primarily health clinics?

Peggy O'Brien: That's a good a question and there are number of different kinds of G codes and I think I'd want to defer that. Clearly, we're intending that you use them, and I believe that all the measures that are in the BHC measures that incorporate G codes, not all of them were designed specifically for Medicare populations. So that may not be the case.

In terms of setting, I can't answer that. A lot of these measures were developed for, say, primary care settings like the screening for alcohol use and the screening for tobacco use and are being used in this -- for this program to provide a set of measures that are considered to be appropriate for behavioral health clinics as well.

If you find, and I do want to find out a good answer to this question, but if it is true that the G codes cannot be turned on for behavioral health clinics, or they cannot be used for Medicaid, then what would have to happen is that the clinics would need to have some other mechanism for coding the results of, say, the BMI whether it was normal, not normal, whether follow-up occurred, things like that. There has to be some mechanism for actually collecting this. But I do want to find out a better answer to this question than I can provide off the top of my head.

Operator: There's a question from Jerry Stork. Do you have any information about the national evaluation and whether they will be using these measures or other measures?

Peggy O'Brien: Actually, Judy, are you still there? We do have --

Judy: I am. We will be using these measures. And we may also calculate additional ones if possible, but we would be using these measures.

Operator: There's question from Carrie Trevor. When will [samhsa.gov/section233/webinars](https://www.samhsa.gov/section233/webinars) be updated to include Webinar 5?

Peggy O'Brien: Actually, it's posted on the SAMHSA YouTube channel now. I think it went on there yesterday. And there also will be a version of it that is posted as a PDF that can be downloaded as a PDF. And we have to wait until it was posted on YouTube which happened yesterday before we could submit the PDF to the SAMHSA webmaster. So that should happen before too long, it's in the works.

Operator: There's a question from [Nan Ganther]. Our record creates a QRDA-3 file uploadable. Is it possible this would be an alternative to using the G codes?

Peggy O'Brien: That's a question I cannot answer off the top of my head. I would need to talk to people to answer that one.

Operator: There are no additional questions at this time.

Peggy O'Brien: Okay. Alright. That is the end of Webinar 7. Thank you for listening and thank you for your questions. And Webinar 8 will be in two weeks in the first week of September, Tuesday at 2 o'clock. See you then.